LOS ANGELES COUNTY COMMISSION FOR CHILDREN AND FAMILIES

Celebrating 26 Years of Advocacy & Achievement

October 14, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: Patricia Curry, Chair, Commission for Children and Families

Donald D. Meredith, President, Probation Commission

RE: RECOMMENDATIONS FOR A PROTOCOL FOR REPORTING PROBATION YOUTH FATALITIES TO THE BOARD OF SUPERVISORS

In December 2009, your Children's Deputies suggested it would be helpful if the Commission for Children and Families worked with the Probation Commission to develop a protocol for reporting youth fatalities within the Probation Department to the Board of Supervisors. The workgroup was comprised of Commissioners from both Commissions as well as members from the Probation Department, forming an Ad-Hoc workgroup to accomplish this task.

The workgroup reviewed procedures currently being used by the Probation Department, as well as, the draft protocol being developed by the Probation Department. The workgroup also reviewed the protocol that is used by the Department for Children and Family Services (DCFS) for reporting child fatalities.

Since the majority of Probation Youth (nearly 19,000) are under supervision at home, a system which cross checks the names of youth has proven to be the only avenue to quickly collect probation youth fatality information. This is done by cross checking the names of every youth, ages 12-17, reported by the Los Angeles County Department of Coroner against the names in the Probation system. However, it is simply a list with no protocol or investigation of systemic issues and no log that can give an overview of cause or geography.

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The 24-hour investigation conducted by the Probation Department is a "paper investigation" up the chain of command. This information is sent to the Chief Probation Officer by one of his deputies within one business day and the Chief Probation Officer reports to the Board of Supervisors within one to two days of receiving this information.

A review of past youthful probationer deaths revealed the majority occur when the minor is out of custody under the supervision of the department with leading causes being homicide, suicide, accident and drug overdose. All death investigations are the responsibility of the local law enforcement jurisdiction so the Probation Department's investigation is administrative. This internal review should be focused on prevention. By reviewing a fatality with an internal examination of practices, policies and procedures, the Department has the opportunity to determine if the death could have been prevented. It provides the Department a chance to review not only its practices and employees, but that of subcontracted community based organizations and group homes.

The draft protocol being developed by the Probation Department is primarily a reporting tool, not an investigative tool, and does not accomplish the objectives indicated above. The draft protocol also does not include many of our recommendations. While the workgroup agreed on the following recommendations, we understand that each one of these would be reviewed by County Counsel before any implementation.

1. Create a specific administrative review team to fully examine each fatality, to gather all information beginning with the Deputy Probation Officer, collateral contacts from other departments (i.e. DCFS, DMH, etcetera), and to include consultation with teachers and family; (*Note: The suggestion from the Probation Department workgroup members is that the review team be made up of the four Department administrative analysts and a rotating Bureau Chief for a centralized review*.)

2. Report conclusions, particularly if systemic issues are identified, to the Board of Supervisors, Justice and Children's Deputies normally in 30-60 days;

3. Improve case management documentation to be more specific. For example, if the youth threatened suicide -- what followed? If a youth required drug or alcohol treatment -- was it obtained? Was the youth in school? What kind of health services and medications were provided? Was the youth AWOL?

4. Establish a log that is similar in nature to the fatality log that is kept by DCFS which includes: youth's first name and first letter of the last name, date of birth, date of death, referral date, Service Planning Area (SPA) Office, SPA number, Probation Status, Placement Type, Mode of Death, Cause of Death, Child Fatality Cause, Circumstances, Ethnicity, Race, and ZIP Code. The log should be reviewed quarterly and reported to the Chief Probation Officer;

5. The protocol being developed by the Probation Department is titled, "Juvenile High Profile Case Notification Procedures." It is understood that all fatalities are "high profile" and include all youth under Probation jurisdiction.

Our Commissions respectfully request that these recommendations be considered by your Board for implementation by the Probation Department in order to provide vital information that can help prevent deaths of probation youth in the future.

SF:PC:ma

c: Chief Executive Officer
Executive Officer, Board of Supervisors
DCEO, Public Safety
DCEO, Children & Families Well-Being
Chief Probation Officer
County Counsel
Children's Deputies
Justice Deputies

Enclosure (Workgroup Membership)

PROBATION YOUTH FATALITY PROTOCOL WORKGROUP

Membership:

Chair, Susan Friedman, Commission for Children and Families
Carol Biondi, Commission for Children and Families
Helen Kleinberg, Commission for Children and Families
Stacey Savelle, Commission for Children and Families
Donald D. Meredith, President, Probation Commission
Clayton Hollopeter, Probation Commission
Jo Kaplan, Probation Commission
Carol Patchett, Probation Commission
Sharon Harada, Probation Department
Dave Mitchell, Probation Department
Larry Dodson, Probation Department